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Examining the Relationship Between Violence Against Healthcare Workers and Their Levels of Exhaustion, Confidence and Safety

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ABSTRACT

Background: This study aims to determine the relationship between violence against healthcare workers and their burnout, confidence, and safety levels.

Methods: The descriptive and cross-sectional study sample consisted of 535 healthcare workers working in a foundation hospital. Data were collected through a questionnaire. The questionnaire included demographic questions, research questions about violence, "Safety and Confidence Scale of Healthcare Professionals" and "Maslach Burnout Scale". Student's t, Mann Whitney-u, Kruskal-Wallis, Chi-Square, Pearson Correlation, and Linear Regression tests were applied. Statistical significance was accepted as 0.05.

Findings: The majority of the participants were female, between the ages of 26-35, single, and had an associate degree. The perceived safety level of those exposed to violence decreases ($p<0.001$), and burnout level increases ($p<0.001$). Injury as a result of violence significantly decreases the perceived safety level ($p=0.019$). The status of being subjected to violence does not vary according to the employees' demographic characteristics or working life data.

Conclusions: Violence decreases employees' perceived safety level and increases burnout. It is recommended to implement psychological support or rehabilitation programs for healthcare workers to reduce violence-related burnout and increase confidence and perception of safety.

Keywords: Workplace Violence, Healthcare Workers, Burnout, Confidence, Safety.

JEL Classification Codes: HI10, J28, J81

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INTRODUCTION

While workplace violence within the healthcare sector is not a recent occurrence, it persists as a notable issue on a global scale. Moreover, it is reported that violence against healthcare workers is increasing (Schablon et al., 2018; Shi et al., 2020) and has become more intense with the impact of the COVID-19 pandemic (Byon et al., 2022; Rossi et al., 2023).

Violence in all areas of life also manifests itself in the workplace. In addition, the health sector is the most risky in terms of violence (Mento et al., 2020). Healthcare professionals face a heightened risk of encountering non-fatal workplace violence, ranging from 5 to 12 times greater than that observed among workers in diverse sectors (GAO, 2016). However, one in five healthcare workers worldwide experience physical violence in the workplace by patients or visitors each year (Li et al., 2020). Healthcare workers are susceptible to incidents of workplace violence due to their frontline roles within the healthcare system, necessitating close interactions with patients and their relatives (Tian et al., 2020). Given the frequency and impact of violence, it remains important to study the issue and develop interventions for prevention.

BACKGROUND

Violence in Health

Violence in the workplace ranges from aggressive or threatening remarks to murder (CDC, 2002). It is possible to talk about different actors of workplace violence. Within a healthcare organization, occurrences of violence may transpire between employees and individuals present on the premises, including patients, family members, visitors, and external suppliers (external violence), as well as among personnel within the institution itself (internal violence) (Viottini et al., 2020; Yosep et al., 2023). However, past studies show that violence against healthcare workers is

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mostly perpetrated by patients or their relatives (Schablon et al., 2018; Duan et al., 2019; Kobayashi et al., 2020).

Risk factors for workplace violence in healthcare organizations can emanate from either patient-related or organizational sources. Notably, within patient-related factors, a history of substance abuse, a track record of previous violent incidents, and the manifestation of psychiatric illness constitute the most significant risks (CDC, 2002). In addition, low perceived quality of care and the severity of the illness or death of the patient are other factors that lead to violence (Shaikh et al., 2020). Additionally, Yılmaz et al. (2020), in their study, identified that irregular demands from patients and their relatives, including requests for unjustified sick leave reports and non-fulfillment of prescription-related requests, contribute to incidents of violence. On the other hand, organizational factors are mostly caused by the workplace's lack of infrastructure or management problems. These factors encompass insufficient information, prolonged waiting times, crowded and uncomfortable waiting areas, insufficient staffing and equipment, communication breakdowns, and a deficiency in staff training and policies to anticipate and address crises stemming from patient interactions (CDC, 2002; Mento et al., 2020; Aljohani et al., 2021).

Previous studies have reported a higher incidence of violence in specific units within healthcare organizations. In this context, the most violent incidents occur in emergency departments, psychiatry departments, outpatient clinics/waiting rooms, and geriatric units (CDC, 2002; Mento et al., 2020). However, when the characteristics of violence are examined, it is seen that it is most frequently applied as verbal violence (Schablon et al., 2018; Shaikh et al., 2020; Aljohani et al., 2021). Additionally, female employees are reported to experience violence more frequently than their male counterparts (Viottini et al., 2020; Shaikh et al., 2020).

Beyond being a crime, violence among healthcare workers leads to a series of consequences that negatively affect the quality and cost of work (Mento et al., 2020). The aftermath of violence contributes to elevated levels of stress, anxiety, anger, guilt, insecurity, sleep disturbances, burnout, as well as increased levels of anxiety and depression among healthcare workers (Hanson et al., 2015; Schablon et al., 2018; Shi et al., 2020; Mento et al., 2020). Moreover, employees are less likely to be satisfied with their careers (Tian et al., 2020), their motivation decreases (Schablon et al., 2018), their job satisfaction and success at work significantly decrease, and their turnover intentions increase (Zhao et al., 2018; Duan et al., 2019).

Burnout

Burnout is defined as a work-related stress syndrome that occurs as a result of continuous exposure to work stress (De Hert, 2020). It is commonly defined as the recurring physical and emotional exhaustion experienced by employees, particularly those engaged in service provision, as a consequence of their working conditions and exposure to situations involving risk (Gimenez Lozano et al., 2022). Healthcare workers are among the professions at risk for burnout (De Hert, 2020). Employees exposed to violence may experience fear, irritability, anger, depression, anxiety, guilt, humiliation, feelings of helplessness, and frustration. These emotions can reduce the ability of healthcare workers to share and understand the needs of patients and can sometimes be a harbinger of burnout (d'Ettorre et al., 2018).

Prior research underscores the positive correlation between healthcare workers' exposure to violence and the occurrence of burnout (Duan et al., 2019; Kobayashi et al., 2020; Gimenez Lozano et al., 2022).

Confidence and Safety

Safety culture in healthcare is delineated as an organization's dedication to safeguarding both patients and employees from harm (Arnetz et al., 2018). A safe working environment allows healthcare workers to perform their work in peace. On the other hand, violence negatively affects employees' perception of safety in the workplace.

Healthcare workers who perceive their workplace as a place where violence is intense often experience fear and suspicion (Chen et al., 2022). Those affected by violence react in the form of distress, anger, anxiety, helplessness, and frustration and become more cautious, alert, and tense (Schablon et al., 2018). These emotions lead them to defensiveness and conflict, negatively affecting their patient relationships. Moreover, these behaviors subsequently lead to an even greater risk of workplace violence (Chen et al., 2022).

Employees' ability to cope with violence can help mitigate the impact and consequences of violence (Yosep et al., 2023). Low tolerance for violence is also significantly associated with a low sense of safety in the workplace (Copelanda & Henry, 2018). However, employees' trust in violence is also influenced by organizational factors (Chen et al., 2022). One of these factors is the presence of a safe climate in the workplace. Employees in workplaces with a high psychosocial safety climate are more adaptive in reacting to and solving workplace violence problems (Pien et al., 2019). In other words, when employees

perceive the safety climate in the workplace positively, their ability to overcome a violent incident they may encounter increases (Chen et al., 2022).

Health professionals' feeling safe and confident in the working environment contributes to the efficient, effective, and quality service of the employee (Şengül et al., 2019). Therefore, providing a safe working environment in healthcare organizations is essential.

Purpose of the Study and Research Questions

Many studies have been conducted so far on the violence that healthcare workers are exposed to (Shi et al, 2020; Shaikh et al, 2020; Rossi et al, 2023). However, as far as we know, no study has been found that investigates employees' confidence and safety perceptions and burnout levels due to the violence they are exposed to. This study supports the literature in this regard.

The objective of the study is to ascertain the correlation between violence against healthcare workers and their levels of burnout, confidence, and safety. In pursuit of this goal, the following research questions were formulated:

- Does violence against healthcare workers affect their burnout levels?
- Does violence against healthcare workers affect their confidence levels?
- Does violence against healthcare workers affect their safety levels?
- Is there a relationship between health workers' confidence, safety, and burnout levels?

METHODS

Population and Sample: The study population comprises all healthcare professionals at a foundation university hospital providing healthcare services in Istanbul. Within the scope of healthcare professionals, both healthcare professionals (doctors, nurses, health officers, EMTs) and employees working in support services units in the hospital (data entry, patient reception-counseling-orientation personnel, security personnel) were included. Approximately three thousand healthcare professionals work in the hospital where the research was conducted. The study involved 535 healthcare workers, selected through the convenience sampling method.

Data Collection Method and Tool: In the study face-to-face survey method was used. The surveys were collected from 1st October 2022 to 31st October 2022. The data was collected through a questionnaire consisting of four sections. It included demographic questions, research questions about violence, "Safety and Confidence Scale of Healthcare Professionals" and "Maslach Burnout Scale" questions to measure burnout levels.

Demographic and Violence-Related Questions Form: There are seven questions in the demographic data form. Participants were requested to provide information regarding their age, gender, marital status, educational background, profession, duration of professional experience, and the specific unit they were affiliated with. In the second part of the form, participants were asked to answer a total of seven questions about violence, which were created using past studies in order to identify violence and its adverse effects on healthcare professionals. These questions were designed to determine whether the health workers encountered violence in their work environment if they were subjected to violence, the type of violence they experienced, who committed the violence, whether there was an injury as a result of violence, whether they were treated in any health institution, whether a report or leave was taken as a result of the violence, and whether there was a loss of work as a result of violence.

Safety and Confidence Scale of Healthcare Professionals: The scale was developed by Kowalenko et al. (2013) and adapted safety and confidence scale of healthcare professionals into Turkish by Şengül et al. There are seven questions to be answered in total. The lowest score on the scale is 7, and the highest score is 70. The scale consists of two parts. The first part includes the "Safety Scale" consisting of 10-point Likert-type items (1=Strongly Disagree, 10=Strongly Agree), and the second part includes the "Confidence Scale" consisting of four 10-point Likert-type items (1=Not at all confident, 10= Extremely confident). The Safety Scale asks participants to indicate how safe they feel while working. The Confidence Scale asks participants to rate their ability to manage violent patients/visitors. A high score on the scale indicates an increase in safety and confidence management against violence.

In the research, the Cronbach's alpha coefficient for the confidence scale was 0.848, while for the safety scale, it was 0.747.

Burnout Scale Short Form: It was developed by Pines and Aranson and adapted into Turkish by Çapri in 2013 as a "Burnout Scale-Short Form." The scale is answered based on the participants' explanations with seven-point Likert-type (1=Never, 7=Always) statements

to determine the burnout levels of individuals. After reading the questions, the individuals are asked to indicate how often they experience the ten situations specified after reading the questions, using a seven-point scale ranging from one to seven (1=Never, 7=Always), and mark the appropriate item against each item. The higher the score obtained from the scale, the higher the burnout level is considered.

Scores of "2.4 and below" are interpreted as a very low degree of burnout. Scores between "2.5 and 3.4" are interpreted as danger signals for burnout, scores between "3.5 and 4.4" are interpreted as being in a state of burnout, and scores between "4.5 and 5.4" are interpreted as having a very serious burnout problem. Scores of "5.5 and above" are interpreted as needing professional help as soon as possible.

The research revealed a Cronbach's alpha coefficient of 0.901 for the burnout scale.

Data Analysis: SPSS.25 package program was used to analyze the data. Normal distribution analysis was performed by examining the skewness and kurtosis values and Q-Q graphs of the data obtained. Skewness and kurtosis values between -1 and +1 were obtained in all dimensions. Frequency distributions of the obtained data were examined. In order to examine the differences between the groups, Stutent's t-test and Mann Whitney-u Test, which are parametric tests, were applied for differences between two groups, and the Kruskal-Wallis test was applied for more than two groups. The chi-square test was applied for the intergroup differences in the status of being subjected to violence. Pearson Correlation and Linear Regression analyses were performed to examine the relationship between violence against healthcare workers and their burnout, confidence, and safety levels.

Research Ethics: Approval was secured from the Istinye University Scientific Research Ethics Committee on July 28, 2022, during meeting number 2022/07 with decision number 02. Subsequently, an application, accompanied by the obtained permission letter, was submitted to the relevant authority at the hospital where the study is to be conducted. After the written approval was received from the hospital, the research was carried out with healthcare professionals who participated in the study voluntarily. Before the questionnaire was answered, the healthcare workers were informed about the study, and their consent was obtained.

RESULTS

Demographic and Work-Life Data

The study collected data from 535 healthcare professionals working in a foundation hospital. The majority of the participants were female (69%), aged between 26-35 years (43%) and single (53%). Regarding education level, the majority were associate degree graduates (40%). Most participants were midwives, nurses, health officers, and EMTs (27%). Most participants had 1-5 years of experience in the profession (57%) and 37% worked in inpatient clinics (Table 1).

Data on the participants' violence exposure and violence are shown in Table 2. Twenty-nine percent of the participants stated that they had been subjected to violence. The most common violence was verbal (68%) and by the patient's relatives (54%). Almost all of the participants were not injured due to the violence they were subjected to, did not receive treatment in any health institution, and did not lose their jobs due to the violence.

The study found that exposure to violence did not differ according to gender, age, marital status, educational level, occupation, length of service, and employment unit (Table 3).

Confidence, Safety and Burnout Analyses with Violence

When the study participants' scale averages are analyzed, the average safety level is 5.86±0.11, the average confidence level is 6.73±0.10, and the average burnout level is 3.58±0.06. Based on the averages obtained, it is observed that the safety and confidence levels of the participants are at a high level. However, it can be said that employees are in "burnout."

In the study, it was observed that exposure to violence decreased perceived safety level ($p<0.001$) and increased burnout level ($p<0.001$). Injury as a result of violence significantly decreases the level of perceived safety ($p=0.019$). Conversely, the nature of experienced violence exhibited no variation across confidence, safety, and burnout levels, as indicated in Table 4.

A negative yet mild correlation exists between the participants' burnout levels and their confidence ($p < 0.001$; $r = -0.249$) and safety levels ($p = 0.013$; $r = -0.108$). In other words, as employees' confidence and safety levels decrease, their burnout levels increase. On the other hand, the number of incidents of violence was

Table 1. Participants' Demographic Characteristics and Data on Their Working Life

Variable	n	%
Gender		
Female	371	69.3
Male	162	30.3
Unspecified	2	0.4
Age		
18-25	172	32.1
26-35	229	42.8
36 ≤	126	23.6
Unspecified	8	1.5
Marital Status		
Single	281	52.5
Married	247	46.2
Unspecified	7	1.3
Education Level		
Highschool & below	159	29.7
Associate degree	215	40.2
Graduate	133	24.9
Postgraduate	24	4.5
Unspecified	4	0.7
Occupation		
Medical Doctor	55	10.3
Midwives, nurses, health officers, and EMTs	142	26.5
Laboratory assistant, radiology, anesthesia technician/technician	61	11.4
Data entry & reception staff	129	24.1
Others	148	27.7
Work experience (years)		
1-5	304	56.8
6-10	96	17.9
11-15	70	13.1
16 ≤	59	11.0
Unspecified	6	1.1
Work unit		
Inpatient clinics	191	36.6
Outpatient clinics	104	19.9
Administrative Units	16	3.1
Intensive care	39	7.5
Emergency room	21	4.0
Hospital common areas	41	7.9
Operating room	67	12.8
Others	56	10.4

EMTs: Emergency medical technician
Hospital Common Areas: Hospital entrance, corridor, information desk, waiting area
Other: All units and work areas not specified in the table

Table 2. Participants' Violence Experiences and Data on Violence

Variable*	n	%
Exposure to violence (n=535)		
Yes	149	29.1
No	363	70.9
Injury due to violence (n=535)		
Yes	5	0.9
No	530	99.1
Receiving treatment as a result of violence (n=535)		
Yes	3	0.6
No	532	99.4
Loss of job due to violence (n=535)		
Yes	4	0.7
No	531	99.3
Type of Violence (n=149)*		
Physically	35	18.5
Verbal	129	68.3
Bullying/Psychological	25	13.2
Person(s) Perpetrating Violence (n=149)*		
Patient	75	36.9
The relatives of the patient	109	53.8
Colleague	10	4.9
Supervisor/manager	8	3.9
Others	1	0.5

** More than one option can be selected. In cases where violence is both verbal and physical, two options are marked together.*

Table 3. Intergroup Comparison of the Status of Being Subjected to Violence

		Experiencing Violence			
		Yes	**No**	**Total**	
Gender					
Female	Count	102	254	356	
	Exp. Count	104.0	252.0	356.0	Value= 0.181
Male	Count	47	107	154	Df= 1
	Exp. Count	45.0	109.0	154.0	p= 0.670
Total		149	361	510	
Age					
18-25	Count	43	125	168	
	Exp. Count	49.7	118.3	168.0	
26-35	Count	73	142	215	
	Exp. Count	63.6	151.4	215.0	Value=4.059
36-45	Count	21	62	83	Df=3
	Exp. Count	24.5	58.5	83.0	p=0.255
46 ≤	Count	12	26	38	
	Exp. Count	11.2	26.8	38.0	
Total		149	355	504	
Marital Status					
Single	Count	72	196	268	
	Exp. Count	78.0	190.0	268.0	Value=1.393
Married	Count	75	162	237	Df=1
	Exp. Count	69.0	168.0	237.0	p=0.238
Total		147	358	505	

Education Level					
≥ Highschool	Count	40	113	153	
	Exp. Count	44.6	108.4	153.0	
Associate degree	Count	62	141	203	Value=0.951
	Exp. Count	59.1	143.9	203.0	Df=2
Graduate ≤	Count	46	106	152	p=0.621
	Exp. Count	44.3	107.7	152.0	
Total		148	306	508	
Occupation					
Medical Doctor	Count	13	42	55	
	Exp. Count	16.0	39.0	55.0	
Midwives, nurses, health officers, and EMTs	Count	40	99	139	
	Exp. Count	40.5	98.5	139.0	
Laboratory assistant, radiology, anesthesia technician/technician	Count	17	36	53	Value=5.837
	Exp. Count	15.4	37.6	53.0	Df=4
Data entry & reception staff	Count	45	79	124	p=0.212
	Exp. Count	36.1	87.9	124.0	
Others	Count	34	107	141	
	Exp. Count	41.0	100.0	141.0	
Total		149	363	512	
Work experience (years)					
1-5	Count	85	208	293	
	Exp. Count	84.5	208.5	293.0	
6-10	Count	28	64	92	
	Exp. Count	26.5	65.5	92.0	Value=0.296
11-15	Count	17	47	64	Df=3
	Exp. Count	18.5	45.5	64.0	p=0.961
16 ≤	Count	16	41	57	
	Exp. Count	16.4	40.6	57.0	
Total		146	360	506	
Work unit					
Inpatient clinics	Count	58	130	188	
	Exp. Count	55.4	132.6	188.0	
Outpatient clinics	Count	29	70	99	
	Exp. Count	29.2	69.8	99.0	
Intensive care	Count	13	25	38	
	Exp. Count	11.2	26.8	38.0	Value=3.354
Emergency room	Count	8	12	20	Df=5
	Exp. Count	5.9	14.1	20.0	p=0.646
Operating room	Count	17	43	60	
	Exp. Count	17.7	42.3	60.0	
Others	Count	22	72	94	
	Exp. Count	27.7	66.3	94.0	
Total		147	352	499	

EMTs: Emergency medical technician

Table 4: Comparison of Participants' Confidence, Confidence and Burnout Levels

		Confidence				Safety				Burnout			
	n	Mean	SD	t/Z/H	p	Mean	SD	t/Z/H	p	Mean	SD	t/Z/H	p
Being subjected to violence [a]													
Yes	149	6.65	2.33	-0.580	0.562	4.75	0.19	-6.477	**<0.001**	4.50	0.09	11.593	**<0.001**
No	361	6.78	2.29			6.31	0.13			3.21	0.06		
Injury as a Result of Violence [b]													
Yes	5	6.30	3.70	-0.060	0.952	2.80	3.48	-2.351	**0.019**	4.66	1.20	-1.906	0.057
No	528	6.73	2.29			5.89	2.54			3.57	1.27		
Type of Violence [c]													
Physically	13	7.28	1.60	4.763	0.313	5.13	2.23	5.459	0.243	4.42	1.16	0.668	0.955
Verbal	88	6.37	2.37			4.74	2.34			4.57	1.06		
Bullying/Psychological	6	8.03	2.34			6.61	2.03			4.56	1.50		
Physical/Verbal	22	6.69	2.40			4.17	2.24			4.31	1.26		
Verbal/Bullying/Psychological	19	7.06	2.44			4.54	2.70			4.43	1.21		

found to have a negative and weak relationship with the level of safety (p=0.011; r=-0.210) and a positive and weak relationship with the level of confidence (p=0.026; r=0.184). These data suggest that as the frequency of violence to which employees are exposed increases, the level of safety decreases, and the level of confidence increases (Table 5).

Table 5: The Relationship Between Burnout, Confidence, Safety Levels, and Number of Violence Experiences

	Mean (SD)	1	2	3
1.Burnout	3.58 (1.27)			
2.Safety	5.86 (2.56)	-0.249**		
3.Confidence	6.73 (2.30)	-0.108*	0.063	
4.Number of Exposures to Violence	2.30 (2.50)	0.016	-0.210*	0.184*

*p < .05, **p < .01

DISCUSSION

Across the globe, healthcare personnel face a significant challenge posed by violence. In Turkey, although the Ministry of Health has made various legislative arrangements for employee safety since 2009, the existence of violence continues to be an important problem (TBMM, 2013). This research, conducted within a foundation hospital, aimed to investigate the correlation between violence and the burnout, confidence, and safety levels of healthcare professionals.

According to the study findings, nearly one-third of the hospital staff experienced violence at least once in their professional lives. Various studies conducted in different countries reveal diverse prevalence rates of violence among healthcare workers. Shi et al. (2020) reported a workplace violence prevalence of 47.9% among physicians and nurses. According to Shaikh et al. (2020), more than a third of employees (38.4%) have been exposed to any form of violence in the last 6 months. In emergency departments, this rate rises to 77% (Aljohani et al, 2021). Studies in our country have also identified rates exceeding 80% (Özdevecioğlu, 2003; Erkol et al., 2007). Among the determinants of violence, there are many organizational-specific factors, such as the physical structure of the health institution, patient-employee relations, and the staff's workload (CDC, 2002; Mento et al., 2020; Aljohani et al., 2021). Therefore, it is expected that the prevalence of violence is at such different levels in studies.

Despite a higher incidence of violence among women, newcomers to the profession, individuals working in patient counseling and reception services, and those employed in inpatient clinics, the study did not identify any statistically significant differences between the groups regarding exposure to violence based on the considered variables. This result shows that violence is applied to all employees in our country at similar rates. On the other hand, the literature shows that women, nurses, and those working in psychiatric units are exposed to violence more (CDC, 2002; Li et al., 2020). This may be attributed to the higher number of female employees in the health sector, the fact that nurses are the professional members who have the most contact with patients (George et al., 2020), and that the patient profile in psychiatric units consists of individuals who are more prone to violence (Kumari et al., 2020), and that the clinical picture of the patient in the emergency department is critical (Shaikh et al., 2020).

Consistent with existing literature, this study found that verbal violence was the most prevalent form, aligning with findings from studies by Shaikh et al. (2020), Aljohani et al. (2021), and Byon et al. (2022). However, tragically, it is a fact that many healthcare workers in Turkey have recently lost their lives in the line of duty due to violence (Independent Turkish, 27.09.2023). On April 17, 2012, after Dr. Ersin Arslan was stabbed to death by a patient's relative in Gaziantep province, health workers across the country stopped work and demanded urgent measures to be taken (saglikcalisanisagligi.org, 20.04.2012). In 2012, ten distinct proposals were presented to the Grand National Assembly of Turkey with the aim of examining instances of violence against healthcare workers and identifying appropriate measures to address the issue. As a result of evaluating the proposals, it was decided to establish a Parliamentary Investigation Commission to "*Investigate the Increasing Incidents of Violence against Health Workers and Determine the Measures to be Taken*" (TBMM, 2013). Despite the commission's field investigations and detailed reports, violence in healthcare has still not been prevented. Moreover, the COVID-19 pandemic has increased violence in health services (Byon et al, 2022), showing that violence will remain a serious problem in healthcare.

Within this study, individuals subjected to violence exhibited a decline in their safety perception and a rise in their levels of burnout. However, a negative correlation was observed between confidence, safety levels, and burnout. This result shows that employees whose perception of safety in the workplace decreases in the face of violence experience more intense burnout. Similarly, Copelanda and Henry (2018) reported that burnout levels increase as employees' perception of safety decreases. Based on this result, it is thought that increasing the level of safety can protect employees from burnout. Moreover, implementing measures that increase employees' perception of safety also helps to protect them from violence (Copelanda & Henry, 2018).

It is emphasized that confidence plays a crucial role in shielding employees from the repercussions of violence (Hanson et al., 2015). Furthermore, enhancing the coping skills of healthcare workers is deemed essential to enable them to effectively manage and prevent violence (Chen et al., 2022). In this context, interventions aimed at preventing violence and safeguarding staff from its detrimental effects are recommended. Whether employing skills training programs, cognitive-based training, or

workplace violence training, all these interventions are reported to yield positive outcomes (Yosep et al., 2023). Interestingly, this study uncovered a positive correlation between the frequency of exposure to violence and the level of confidence. This correlation is believed to be attributed to the predominantly verbal nature of the experienced violence and the low incidence of physical harm, fostering a perception among employees that they can adequately cope with such instances.

Workplace violence is posited as a long-term and/or cumulative stressor rather than a brief and extreme fear-inducing event (Kobayashi et al., 2020). Consequently, this enduring stress contributes to employee burnout (Copeland & Henry, 2018; Duan et al., 2019; Kobayashi et al., 2020) and heightens turnover intentions by diminishing job satisfaction (Duan et al., 2019). Introducing measures to augment employees' sense of safety can shield them from violence and alleviate burnout (Copeland & Henry, 2018). In this context, regular implementation of support and training programs for healthcare institution employees is believed to be effective in combating violence.

Organizational factors such as inadequate information, prolonged waiting times, crowded and uncomfortable waiting areas, insufficient staffing and equipment, and communication breakdowns are recognized as contributors to violence in healthcare institutions (CDC, 2002; Mento et al., 2020; Aljohani et al., 2021). A study conducted in Turkey identifies significant complaints affecting patient dissatisfaction, including insufficient staff, lack of cleanliness and hygiene, inadequate information for patients and their relatives, and a bustling and noisy environment (Yaman, 2019). Another study suggests that enhancing service delivery, optimizing resource utilization, adjusting service delivery to meet demand, maintaining a manageable patient load, having adequately staffed personnel, and employing patient counselors and counseling staff can contribute to violence prevention (Yıldız, 2019). Consequently, addressing the infrastructure and personnel deficiencies of healthcare institutions is deemed crucial for achieving meaningful success in the fight against violence.

IMPLICATIONS FOR PRACTICE

Workplace violence, described as a global health problem, has negative effects on healthcare workers.

This study revealed that approximately one-third of healthcare workers experienced violence at least once during their professional careers, with verbal aggression being the most common form, predominantly perpetrated by patients' relatives. Fortunately, a minimal number of individuals subjected to violence reported physical injuries, treatment repercussions, or job loss. However, despite these mitigating factors, the observed effects of violence persist. Individuals who experienced violence conveyed a diminished sense of safety in their work environment, coupled with elevated levels of burnout compared to their non-exposed counterparts. Furthermore, a discernible correlation was noted between diminishing safety perceptions and escalating burnout levels.

Healthcare professionals work under intense pressure and challenging conditions. In particular, the COVID-19 pandemic has reminded the world again how important a task this professional group performs. On the other hand, unfavorable working conditions cause many healthcare professionals to experience intense burnout and consequently leave the sector. Workplace violence is also one factor that increases healthcare professionals' burnout.

It is recommended to implement psychological support or rehabilitation programs for healthcare workers to reduce violence-related burnout and increase confidence and perception of safety.

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